STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING _____ B. WING _____	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated/Partial Extended Survey was initiated on 07/15/15 and concluded on 07/23/15, to investigate four (4) complaints (KY23535, KY23527, KY23562 and KY23564). Complaints KY23527, KY23562 and KY23564 were unsubstantiated with no deficiencies identified. The Division of Health Care substantiated complaint KY23535 with Immediate Jeopardy identified on 07/17/15 and determined to exist on 06/30/15. The facility was notified of the Immediate Jeopardy on 07/17/15 at 42 CFR 483.20 Resident Assessment (F282) at a scope and severity of a "J"; 42 CFR 483.25 Quality of Care (F309 and F323) at a scope and severity of a "J"; and, 42 CFR 483.75 Administration (F490, F498, and F520) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. Immediate Jeopardy was determined ongoing at the time of exit on 07/23/15. The facility will be involuntarily terminated on 07/25/15. On 06/30/15 at approximately 10:30 AM, Certified Nursing Assistant (CNA) #1 attempted to transfer Resident #1, without assistance, via a mechanical lift when the lift tilted forward causing the metal bar to strike the resident across the face. The resident sustained a head injury from the metal bar of the mechanical lift causing a hematoma (collection of blood under the skin) on the resident's forehead. Interview and record review revealed the resident did not receive a complete nursing assessment until 12:30 PM when the nurse noticed a 2 centimeter by 1.5 centimeter hematoma on the right side of the resident's forehead.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/23/2015

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F 000	Continued From page 1 On 07/10/15, Resident #3 fell from the bed. The nursing assessment revealed the resident did not sustain an injury related to this fall. However, the resident had a history of pain and continued to complain of pain. Interview and record review revealed the facility failed to assess or monitor the resident for a change in condition due to the resident's history of pain. On 07/11/15, during State monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur. The facility is in continued non-compliance from an abbreviated survey completed on 05/22/15 in which Immediate Jeopardy was also identified at 42 CFR 483.20 Resident Assessment (F282); 42 CFR 483.25 Quality of Care (F309 and F323); and, 42 CFR 483.75 Administration (F490 and F520).	F 000		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy and an incident report review and review of the	F 282		

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Invacare Manufacturer's User Manual, it was determined the facility failed to have an effective system in place to ensure the staff followed the resident's care plan for two (2) of five (5) sampled Residents (Residents #1 and #3). The facility failed to ensure two (2) nursing staff operated the mechanical lift for Resident #1 as care planned. In addition, the facility failed to monitor Resident #3 for a change in condition after the resident sustained a fall resulting in a hip fracture.

On 06/30/15, Certified Nursing Assistant (CNA) #1 failed to follow the care plan for Resident #1 when a transfer was attempted without the extensive assistance of two (2) nursing staff for transfers to and from bed using a mechanical lift. The resident sustained injuries to the forehead when the nurse aide lost control of the lift and it tilted causing the lift bar to strike Resident #1's forehead, resulting in severe bruising of the forehead, the peri-orbital areas (area surrounding the eyes), and the right cheek.

Resident #3 had a history of falls. The resident's care plan directed the staff to monitor for changes in condition that may warrant an increase in supervision and assistance. Resident #3 sustained a fall from the bed, on 07/10/15, which was described as a non-injury fall. However, there was no documented evidence the staff monitored the resident for a change in condition. Interview with staff revealed the resident complained of pain but staff did not assess this as a change in condition due to the resident's prior history of pain. On 07/11/15, during State monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident's allegation to the

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facility staff. On 07/12/15, two (2) days after the fall and after Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur.

The facility's failure to have an effective system in place to ensure care plan interventions were implemented related to the use of the mechanical lifts and monitoring after a fall has caused or is likely to cause serious injury, harm, impairment or death to residents. Immediate Jeopardy was identified on 07/17/15 and was determined to exist on 06/30/15 and is ongoing.

The findings include:

The facility did not provide a policy regarding following care plans.

Review of the facility's policy regarding Fall Prevention-Kardex/Care Plan, dated June 2015, revealed the Kardex contained information on preventative measures for falls. Per the policy, the Kardex should be updated and verbal report given to staff for any changes in the resident's plan.

Review of the facility's policy for Low Lift, part of the Low Lift Program, dated 11/30/14, revealed the facility identified the transfer needs of each resident. The resident's lift status was indicated on the care plan, Kardex, and by identifiers placed by the resident's name at the resident's door.

Review of the Invacare Manufacturer's User Manual for mechanical lifts, dated 2013, Chapter 7, Lifting the Patient, item 7.1 page 28, revealed

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Invacare recommended that two (2) assistants be used for all lifting and transferring.

1. Review of Resident #1's clinical record, on 07/15/15, revealed the facility admitted the resident on 07/23/07 with diagnoses of Pseudobulbar Affect (A neurological disorder characterized by involuntary crying, laughing, or other emotional displays), Diabetes, Congestive Heart Failure, Intellectual Disability and Bipolar Disorder.

Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 06/23/15, revealed the resident was not able to participate in the Brief Interview for Mental Status (BIMS) and the facility assessed the resident as severely impaired and rarely or never made decisions. The resident was assessed to need the extensive assistance of two (2) for bed mobility and transfers. The resident was unable to ambulate or stand.

Review of the Comprehensive Care Plan of Resident #1, dated 04/08/14, revealed the resident required extensive to dependent assistance with activities of daily living. An intervention was added on 04/30/15 for the resident to have two (2) assistants, and a mechanical lift for transfers to and from the bed.

Review of the Nurse Tech Information Kardex, undated, revealed Resident #1 required the assistance of two (2) nursing staff to transfer using a full body mechanical lift with an extra large Invacare sling.

Review of the Situation Background Appearance Review (SBAR) Communication Form, dated

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06/30/15 and signed at 2:00 PM, revealed a Situation occurred for Resident #1, on 06/30/15, which resulted in a hematoma over the right eye area and ice was applied to the forehead. The Review Section of the form revealed the resident was being transferred, by a Certified Nurse Aide (CNA), from bed to a wheelchair per a lift and the lift came off the floor and the resident went down toward the wheelchair. The CNA grabbed the resident with the help of another CNA and a nurse then assisted the resident into the wheelchair.

Interview with CNA #1, on 07/16/15 at 4:52 PM, revealed she worked for an Agency and had been working at the facility for three (3) months. She stated she had provided care for Resident #1 in the past and was aware of the care instructions for Resident #1 to use a mechanical lift for transfers. Per interview, she was aware of the policy for two (2) persons to use a mechanical lift and follow the care plan. She stated the Kardex care plan did say that two (2) persons were to use the lift to transfer residents; however, everyone was busy and she did not notify her supervisor. She further revealed technically when the other CNA entered the room to help, there were two (2) persons. She stated there was no reason the transfer could not have waited until assistance was available.

Review of the Witness Statement by CNA #1, not dated, revealed the Director of Nursing (DON) interviewed CNA #1 related to the incident with Resident #1 on 06/30/15. The CNA stated she was attempting to transfer Resident #1 using a lift, when the lift tipped over and hit the resident in the head.

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Interview with CNA #2, on 07/16/15 at 5:12 PM, revealed she was in the hallway doing rounds when she heard Resident #1 crying out. She stated she went to Resident #1's room and saw CNA #1 trying to hold on to the resident while the resident was suspended in the sling and the lift was tilted. She stated she grabbed the sling with the resident and pulled the sling until it was over the wheelchair and the resident was lowered to the chair. She stated the resident was not able to stand and required the lift and two (2) persons to get to and from bed.

Interview with Licensed Practical Nurse (LPN) #2, on 07/16/15 at 11:16 AM, revealed she was working on the locked unit, on 06/30/15 at around 10:30 AM, when she heard loud yelling out. She stated CNA #2 entered the resident's room and she was right behind her. LPN #2 stated CNA #1 had Resident #1 in the lift which was tilted over. She stated CNA #1 was holding the resident and attempting to get the resident seated into a wheelchair which was also tilted over. Continued interview revealed CNA #2 grabbed the lift sling, with the resident, and pulled the sling until the resident was over the wheelchair and could be lowered into the chair. She stated CNA #1 was using the lift alone and the care plan and policy required two (2) persons to use the lift on a resident.

Interview with the DON, on 07/16/15 at 11:53 AM, revealed she was aware the CNA did not follow the care plan when she attempted to transfer Resident #1 from the bed to a chair alone. She stated the CNAs were required to follow residents' care plans when providing care to ensure resident safety.

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Interview with the Regional Director of Clinical Services, on 07/16/15 at 8:28 AM, revealed she suspected the CNA used the lift alone instead of with two (2) persons as directed by the care plan.

2. Review of the clinical record for Resident #3, revealed the facility admitted the resident, on 05/16/13, with diagnoses of Anemia, Incontinence, Dementia, Anxiety and Diabetes.

Review of the Quarterly MDS assessment completed by the facility on 06/08/15, revealed Resident #3's Brief Interview for Mental Status was a nine (9) and the resident was interviewable. The resident required extensive assistance with two (2) assistants for bed mobility and transfers. The resident could not stand or ambulate.

Review of Resident #3's Comprehensive Care Plan, dated 06/09/15, revealed the resident was at risk for falls, due to his/her overall physical condition and use of psychotropic medications with interventions to monitor for changes in condition that may warrant increased supervision/assistance.

Review of the SBAR, dated 07/10/15, revealed Resident #3 was found on the floor next to the bed and there were no injuries.

Interview with Resident #3, on 07/11/15 at 10:14 AM during State monitoring of the facility, revealed he/she felt beaten from head to toe and was in pain. The SSA reported the resident's comments to the Corporate Nurse Consultant, who was working onsite at the facility.

Review of the clinical record revealed no

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documented evidence Resident #3 was monitored for a change in condition after the 07/10/15 fall. Further review of the clinical record revealed the resident was sent to the hospital on 07/12/15 with a fractured right femur.

Interview with CNA #4, on 07/17/15 at 6:15 PM, revealed she provided care for Resident #3 and the resident complained of pain or soreness routinely when turned or moved. She stated the resident received pain medication around the clock.

Interview with LPN #1, on 07/17/15 at 5:50 PM, revealed she did not identify the location of the pain, the duration of the pain, or if there were any precipitating factors when the resident complained of pain. She stated the resident's care plan should be followed related to monitoring for change in condition.

Interview with Registered Nurse (RN) #1, on 07/17/15 at 5:50 PM, revealed Resident #3 complained of soreness anytime he/she was moved. She stated she did not think Resident #3's pain was any different than usual after the fall on 07/10/15. She stated she sometimes asked the residents to identify the location of the pain; however, she did not ask about the duration of the pain, or if there were any precipitating factors. She stated the resident's care plan should have been followed related to monitoring for a change in condition.

Interview with the DON, on 07/20/15 at 2:56 PM, revealed care plans should be followed. She stated Resident #3's pain was assessed every shift; however, she was unable to say if the staff monitored the resident and asked about location,

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F 282	Continued From page 9 duration or precipitating factors.	F 282		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to have an effective system in place to assess and monitor residents after an incident or fall for two (2) of five (5) sampled residents (Residents #1 and #3). On 06/30/15 at approximately 10:30 AM, Certified Nursing Assistant (CNA) #1 attempted to transfer Resident #1, without assistance, via a mechanical lift when the lift tilted forward causing the metal bar to strike the resident across the face. The resident sustained a head injury from the metal bar of the mechanical lift causing a hematoma (collection of blood under the skin) on the resident's forehead. Interview and record review revealed the resident did not receive a complete nursing assessment until 12:30 PM when the nurse noticed a 2 centimeter by 1.5 centimeter hematoma on the right side of the resident's	F 309		

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forehead.

On 07/10/15, Resident #3 fell from the bed and was assessed as uninjured; however, the resident had a history of pain and continued to complain of pain. Interview and record review revealed the facility failed to assess or monitor the resident for a change in condition due to the resident's prior history of pain. On 07/11/15, during State monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur.

The facility's failure to have an effective system in place to assess and monitor residents after an incident and/or fall has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing.

The findings include:

Review of the facility's policy for Resident Incident/Accident, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions.

Review of the facility's Situation, Background,

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Appearance Review (SBAR) Communication Form, dated 2014, revealed the situation of the incident; background of the resident's care; resident's evaluation; the appearance of the resident; and, the review and notification to the physician and also to the responsible party was to be documented.

Review of the facility's policy for Neurological Assessment, undated, revealed these assessments would be completed every fifteen (15) minutes for one (1) hour, every hour for four (4) hours, then every four (4) hours for nineteen (19) hours. The assessment covered level of consciousness; pupil response; hand grasps; extremities motor function; pain response; vital signs; and observations.

1. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 07/23/07 with diagnoses of Dementia, Pseudobulbar Affect (a neurological disorder characterized by outbursts of crying, laughing and other emotional expressions), Bipolar Disorder, and Diabetes.

Review of Resident #1's quarterly Minimum Data Set MDS) assessment, dated 06/23/15, revealed the resident was not able to complete the Brief Interview for Mental Status (BIMS) and was determined to have a severe cognitive impairment and was not interviewable. The resident required extensive assistance of two (2) persons for bed mobility and transfers. The resident could not ambulate or stand and was incontinent. The resident was assessed to require a total body lift with a sling and full staff performance on, 04/30/15.

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Review of the Comprehensive Care Plan, dated 04/08/14, revealed Resident #1 required extensive assistance for activities of daily living. On 04/30/15, an intervention was added to the care plan for the resident to use a total body lift with the assistance of two (2) persons. The nurse aide Kardex was marked with these directions as well.

Review of a hand written statement by CNA #1, dated 06/30/15, revealed she was getting (Resident #1) up on the lift "this morning about 9:30 AM" and when she had the resident over the chair CNA #2 walked in to assist her. Per the statement, CNA #2 grabbed the lift pad and proceeded to pull the resident back in the chair, while she lowered the resident and "the lift tilted over hitting (the resident) and the CNA in the head". However, CNA #2 reported she was in the hallway making rounds when she heard Resident #1 crying out repeatedly. She rushed into the room and saw the resident dangling in the lift sling with the lift tilted.

Interview with Licensed Practical Nurse (LPN) #2, on 07/16/15 at 11:16 AM, revealed she heard Resident #1 crying out over and over on 06/30/15 at 10:30 AM. She entered the room and saw the resident in the lift sling and the lift was tilted. Per interview, CNA #2 had the lift sling in her hands; pulled the resident into the wheelchair; and, when the resident went down into the wheelchair, CNA #2 was hit in the head by the lift. She stated she saw pinkness on the resident's forehead and was suspicious, but thought the pinkness was caused by the resident crying out repeatedly.

Review of the clinical record revealed no documented evidence the resident was assessed

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or monitored for potential injury between 10:30 AM and 12:30 PM.

Review of the Situation, Background, Appearance, and Review (SBAR) Communication Form, dated 06/30/15 and signed 2:00 PM, revealed a Situation occurred for Resident #1, on 06/30/15, which resulted in a hematoma over the right eye area, ice was applied to the forehead, and the resident's condition had "gotten Worse". Documented on the form in the section titled Other Relevant Information revealed the bar from the lift likely hit the resident in the head. The Skin Evaluation revealed a hematoma was present above the right eye into the hairline with no open areas. The Pain Evaluation revealed the resident had pain, the pain was new, the resident was showing non-verbal signs of pain, was crying out at times and would voice pain with contact. The Advance Practice Registered Nurse (APRN) was notified at 12:30 PM. The Responsible Party was notified at 1:00 PM.

Review of the Physician's orders, dated 06/30/15, revealed Resident #1 was placed on neurological assessments at 12:30 PM.

Review of the Neurological Assessments, dated 06/30/15 and 07/01/15, completed for Resident #1, revealed no documented observation of the hematoma to the resident's right forehead.

Review of Resident #1's Nursing Progress Notes, dated 06/30/15 at 6:00 PM, revealed initially there were no signs of injury when the resident was taken to the dining room for lunch at 11:40 AM. At 12:30 PM, a hematoma was noted measuring 2 centimeters by 1.5 centimeters on the residents forehead. The Advanced Practice Registered

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Nurse (APRN) was notified. She ordered neurological assessments to be obtained and to hold the resident's aspirin for seven days. The APRN arrived on the unit between 2:00 PM and 2:30 PM to examine the resident. A Computed Tomography (CAT) Scan of the head was ordered to be completed at an outpatient location. The findings of the CAT Scan revealed the resident had a hematoma over the right side of the forehead.

Review of a Non-pressure Skin Record, dated 06/30/15 without a time, revealed Resident #1's hematoma measured eight (8) centimeters by six (6) centimeters. Record review revealed no further documentation regarding the hematoma.

Interview with Licensed Practical Nurse (LPN) #2, on 07/16/15 at 11:16 AM, revealed she worked on 06/30/15 and around 10:30 AM, she heard Resident #1 crying out over and over so she rushed to the resident's room. She stated the lift did not hit the resident and she was told by CNA #1 that the lift did not hit the resident when the lift first tilted. However, LPN #1 stated she saw pinkness on the resident's forehead; however, it could have been caused by the resident crying out repeatedly. On 06/30/15 at 12:30 PM, she saw the resident being returned from the dining room and noted a hematoma on the right side of the resident's forehead. She stated she measured the hematoma at 1.5 centimeters by 2 centimeters and notified the physician.

Continued interview with LPN #1 revealed the APRN was in the facility and she received orders for neurological assessments to be completed and she would see the resident. She stated the APRN arrived to see the resident between 2:00

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PM and 2:30 PM and ordered a CAT Scan be obtained from a local outpatient facility. She stated there was some difficulty making arrangements for the resident's CAT Scan and the resident did not leave the facility until 5:30 PM.

LPN #2 continued to state the resident's injury should have been assessed throughout the day and night per policy in order to identify changes that should be brought to the APRN or the physician's attention.

Interview with the APRN, on 07/17/15 at 12:00 PM, revealed she was at the facility when she was notified, around 12:30 PM, that Resident #1 was hit in the head, during a transfer, bruising the right forehead above the eye. She stated she ordered that neurological assessments be completed, held the resident's aspirin dose for seven (7) days and obtained a CAT Scan from an outpatient facility. She stated she saw the resident a little later; however, she was not sure of the time. She stated the resident was examined and had no changes in the baseline neurological status. Per interview, the facility asked her if she wanted to send the resident to the emergency room; however, the APRN stated the resident was stable and she said no. She stated the CAT Scan showed no bleeding or swelling of the brain. She stated the resident did have some vomiting later that evening but she did not feel that was a complication of the injury. However, she stated the bruising to the resident's face was extensive and there was swelling.

Interview with the Director of Nursing, on 07/17/15 at 7:21 PM, revealed nurses were educated to complete a head to toe nursing

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assessment after any accident or incident where an injury may have occurred. She stated Resident #1 was not assessed until some time after the incident. She stated this was a basic part of nursing education.

Observation of Resident #1, on 07/15/15 at 2:47 PM, revealed the resident's forehead was covered with brown and purple bruising from the top of the hairline to below the eyes. The forehead bruising extended from the left hairline to the right hairline. Each eye lid was purple and below each eye was purple and brown bruising with a small amount of swelling. A purple linear bruise extended from the tip of the resident's nose across the cheek to the right earlobe. Continued observation of the resident, on 07/15/15 at 3:55 PM, revealed the resident was awake and verbalized pain.

2. Review of the clinical record for Resident #3, revealed the facility admitted the resident on 05/16/13 with diagnoses of Osteopenia, Pacemaker, Heart Disease, Pressure Ulcer, Hypertension and Dementia.

Review of the quarterly MDS assessment, dated 06/08/15, revealed the resident had a BIMS score of nine (9) and was interviewable. The resident required extensive assistance of two (2) for bed mobility and transfers and was unable to ambulate. The resident was incontinent of bowel and bladder.

Review of Resident #3's Comprehensive Care Plan, dated 06/09/15, revealed the resident was at risk for falls due to overall physical condition and use of psychotropic medications with interventions to monitor for changes in condition

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that may warrant increased supervision/assistance.

Review of the SBAR, dated 07/10/15 at 2:30 PM, and completed by RN #1, revealed Resident #3 was found on the floor on the mat and the resident's condition remained unchanged after the fall and resident was placed back in bed.

Interview with RN #1, on 07/17/15 at 6:04 PM, revealed she did turn Resident #3 in order to change the resident's dressing. She stated the resident usually complained of soreness whenever turned. She stated she examined the resident after the fall on 07/10/15 and did not feel the resident's pain was any different than any other day. She stated the resident drew up his/her legs in response to the examination; however, this was normal for the resident. She stated after the fall, the resident was assessed by a nurse for apparent injuries, had vital signs assessed, and was requested to perform range of motion or had passive range of motion completed by the nurse. However, review of the Orthopedic Surgery Consultation, dated 07/14/15, revealed the resident had flexion contractures of both legs and could only move toes on examination.

Record review revealed no documented evidence the resident was assessed for injury or monitored for increased pain after the fall.

Interview with Resident #3, on 07/11/15 at 10:14 AM during State monitoring of the facility, revealed he/she felt beaten from head to toe and was in pain. The SSA reported the resident's comments to the Corporate Nurse Consultant, who was working onsite at the facility.

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Review of the Nursing Progress Notes, dated 07/11/15 at 12:00 PM, revealed the resident spoke in a soft voice and mentioned something about being beaten up. A complete head to toe nursing assessment was completed with no bruises or signs of trauma noted. An x-ray of the right knee was taken with no deformity noted; however, the resident did complain of pain. At 6:30 PM, the nursing note stated an x-ray was pending.

Review of the clinical record revealed after the nursing assessment, completed on 07/11/15 at 12:00 PM, there was no further documented evidence regarding the monitoring of the appearance of the right knee or the resident's complaint of pain.

Further review of the Nursing Progress Notes, at 7:00 AM on 07/12/15, revealed the facility was told by the x-ray company that the x-ray was not readable. The x-ray was repeated at 10:00 AM on 07/12/15. On 07/12/15 at 7:30 PM, orders were received from the APRN to send the resident to the emergency room where the resident was admitted with a fractured right femur, approximately fifty-five (55) hours after the resident had sustained the fall on 07/10/15.

Interview with CNA #4, on 07/17/15 at 6:15 PM, revealed she had provided care for Resident #3 and the resident usually complained of soreness and pain whenever the resident was turned or transferred. She stated the resident was very fragile and required a mechanical lift to transfer to and from the bed. She stated the resident did complain of pain when moved; however, after the fall on 07/10/15 the resident was transferred to a wheelchair and stayed up for several hours.

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F 309	Continued From page 19 Interview with CNA #5, on 07/17/15 at 6:46 PM, revealed she provided care for Resident #1. She stated the resident had discomfort most of the time and received pain medication routinely. She stated the resident also received medication for anxiety. She stated the resident was transferred to and from bed with a lift and two (2) assistants. She stated she was not told the resident might be injured. She stated transferring a resident with a possible leg or hip problem could cause more damage. Interview with LPN #1, on 07/17/15 at 5:50 PM, revealed she had provided care for Resident #3 one time recently. She stated the resident had not complained of pain. She stated residents should be assessed for injury and observed for signs of pain after an injury. She stated the area of concern should be monitored for changes. Interview with the Director of Nursing, on 07/17/15 at 7:21 PM, revealed the resident could not move either leg due to contractures; however, Resident #3 was assessed by the nurse and found to have no injury. She stated the nurses' ability to complete a head to toe assessment to locate possible injuries was not reviewed for competency. She stated nurses were educated on the basics in school and she did not feel they needed more training in this subject.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies and the Invacare Lift Manual, it was determined the facility failed to have an effective system to ensure each resident received supervision to prevent accidents and failed to identify the root cause of falls to implement interventions to prevent additional falls for two (2) of five (5) sampled residents. (Residents #1 and #3).

On 06/30/15 at approximately 10:30 AM, Certified Nursing Assistant (CNA) #1 attempted to transfer Resident #1, without assistance, via a mechanical lift when the lift tilted forward causing the metal bar to strike the resident across the face. The resident sustained a head injury from the metal bar of the mechanical lift causing a hematoma (collection of blood under the skin) on the resident's forehead.

On 07/04/15 at 6:30 PM, Resident #3 was found on the floor lying on their left side on the floor mat. On 07/10/15 at 2:30 PM, Resident #3 was found on the floor, on the floor mat, and the resident's condition was assessed to be unchanged after the fall. There was no documented evidence the facility identified the root cause of these falls to implement interventions to prevent recurrence. On 07/11/15, during State monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in

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pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and after Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur.

The facility's failure to have an effective system in place to provide adequate supervision and to determine the root cause of accidents/incidents in order to implement interventions to prevent recurrent incidents/falls has caused or is likely to cause serious injury, harm, impairment or death to the resident. The Immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing.

The findings include:

Review of the facility's policy for Resident Incident and Accident Reports, dated 11/30/14, revealed unusual occurrences not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following a nursing assessment, the physician would be notified of any noted or suspected injury, and facility staff would implement appropriate interventions. The event, along with assessment, physician and other required notification would be documented in the resident's clinical record. The resident's family or legal representative would be notified of the incident. Incident reports would be reviewed by the Director of Clinical Services for completion and follow-up. Following review by the Director of Clinical Services, the event would be reviewed by the Interdisciplinary Team and the Executive Director.

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Review of the facility's policy for Fall Prevention, dated June 2015, revealed the investigation of a fall included the determination of the root cause of the fall using the Root Cause Analysis Investigation Form. Use of the Form addressed chart review, medication changes, assessment of the resident, laboratory results, history of falls, change in condition, toileting patterns, and interviews to determine the events surrounding the incident to include the who, what, where and why.

Review of the facility's policy for the Low Lift Program, dated 11/30/14, revealed the facility was committed to providing equipment and resources to achieve, as much as practical, a lift free environment for both residents and staff. The Low Lift Program provided an enhanced margin of safety, allowing the staff to comfortably transfer, transport, and maneuver the residents to meet their individual needs.

Review of the Invacare Lifts Users Manual, dated 2013, Chapter 7 Lifting the Patient, Item 7.1 Preparing the Lift for Use, revealed a recommendation that two (2) assistants be used for all lifting preparation and transferring.

1. Review of Resident #1's clinical record, revealed the facility admitted the resident on 07/23/07 with diagnoses of Dementia, Bipolar Disorder, Intellectual Disability, Diabetes and Pseudobulbar Affect (a neurological condition characterized by outburst of crying, laughing and other emotional expressions).

Review of the Quarterly Minimum Data Set (MDS) assessment completed by the facility on 06/23/15, revealed the facility assessed Resident

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#1 as unable to complete the Brief Interview for Mental Status (BIMS) and was noted to be severely impaired cognitively. The resident required extensive assistance of two (2) persons for bed mobility and transfers. The resident was unable to stand or ambulate.

Review of the Comprehensive Care Plan of Resident #1, dated 04/08/14, revealed the resident required extensive to dependent assistance with activities of daily living. An intervention was added on 04/30/15 for the resident to have two (2) assistants and a mechanical lift for transfers to and from the bed.

Review of the Nurse Aide Kardex, undated, revealed the resident required two (2) assistants to use the lift with an extra large sling.

Review of the Incident Report, dated 06/30/15 and not timed, revealed Resident #1 sustained a hematoma to the right side of the forehead during a transfer using a total body lift. There was no documented evidence of how the injury occurred or if the physician and responsible party were notified when the injury occurred at 10:30 AM.

Review of the Situation, Background, Appearance, and Review (SBAR) Communication Form, dated 06/30/15 and signed 2:00 PM, revealed a Situation occurred for Resident #1, on 06/30/15, which resulted in a hematoma over the right eye area, ice was applied to the forehead, and the resident's condition had "gotten worse". Documented on the form in the section titled Other Relevant Information revealed the bar from the lift likely hit the resident in the head. The Skin Evaluation revealed a hematoma was present above the right eye into the hairline with no open

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areas. Review of the Pain Evaluation revealed the resident had pain, the pain was new, the resident was showing non-verbal signs of pain, was crying out at times and would voice pain with contact. The Review Section of the form revealed the resident was being transferred from the bed to a wheelchair per a lift by a CNA. The lift came off the floor and the resident went down toward the wheelchair. With the help of another CNA and a nurse, this CNA grabbed the resident and assisted him/her into the wheelchair. The Advance Practice Registered Nurse (APRN) was notified at 12:30 PM. The Responsible Party was notified at 1:00 PM.

Review of the Non-Pressure Skin Report, dated 06/30/15 and not timed, for Resident #1, revealed the hematoma had enlarged to 8 centimeters by 6 centimeters at an unknown time.

Observation of Resident #1, on 07/15/15 at 2:47 PM, revealed the resident's forehead was solidly covered with brown and purple bruising from the left hairline to the right hairline. The bruising extended from the top hairline to below the eyes. Both eyes, under the eyes and the eyelids were purple and brown. A purple bruise was noted to extend from the tip of the nose across the cheek to the right earlobe.

Interview with CNA #1, on 07/16/15 at 4:52 PM, revealed she was employed by a local Agency. She stated she was familiar with the residents on the unit and had provided care for Resident #1 in the past. She was aware that each resident had a Kardex outlining the nursing care to be provided. She knew the resident needed a mechanical lift to transfer to and from the bed. Further interview revealed she also knew the

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facility's policy required two (2) persons to transfer a resident using a mechanical lift. However, for Resident #1, she thought she could transfer the resident with the lift without assistance.

Continued interview with the CNA revealed she decided to lift the resident alone since other staff was busy and she did not seek assistance from her supervisor. She said getting the resident up was not urgent, but she continued to do so unassisted. She had the resident in the sling and was swinging the lift out towards the wheelchair when CNA #2 entered the room, grabbed the sling and pulled the resident down into the wheelchair. She stated using the mechanical lift alone was not a safety issue; however, it was the rule of the facility. During this interview the CNA stated the lift bar did not hit the resident when she was performing the lift alone or when CNA #2 entered the room to assist her.

However, review of the Witness Statement by CNA #1, not dated, revealed the Director of Nursing (DON) interviewed CNA #1 related to the incident with Resident #1 on 06/30/15. The CNA stated she was attempting to transfer Resident #1 using a lift, when the lift tipped over and hit the resident in the head.

In addition, review of a hand written statement by CNA #1, dated 06/30/15, revealed she was getting (Resident #1) up on the lift "this morning about 9:30 AM" and when she had the resident over the chair CNA #2 walked in to assist her. When CNA #2 got in the room she got on one side (of the resident) and CNA #1 was on the other side. CNA #2 grabbed the lift pad and proceeded to pull the resident back in the chair,

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and while she lowered the resident, "the lift tilted over hitting (the resident) and the CNA in the head". Per the written statement, after the resident was secured CNA #1 left the floor to tell the DON what had happened. The CNA noted the nurse was not going to report it because the nurse said the resident was not hurt. Per the statement, about 1:00 PM the nurse told CNA #1 to look at (the resident's) head; he/she "got a big knot" on his/her forehead". The nurse stated she would have to report it now, and CNA #1 told her she was too late because CNA #1 had already told the DON what happened to cover herself.

Interview with CNA #2, on 07/16/15 at 5:12 PM, revealed she was in the hallway making rounds when she heard Resident #1 crying out repeatedly. She rushed into the room and saw the resident dangling in the lift sling with the lift tilted. She grabbed the sling and pulled the resident down and into the wheelchair. She stated this caused the lift to shift and the lift bar hit her in the head not the resident. She stated two (2) persons were required to use the mechanical lift for a resident. In addition, she stated this information was listed on the resident's Kardex.

However, review of the Witness Statements, dated 06/30/15, revealed the DON interviewed CNA #2, who stated she heard a loud noise in the resident's room and when she walked in the CNA was standing in the room by the resident who was in the lift. The lift tilted over and hit the resident in the head.

Interview with Licensed Practical Nurse (LPN) #2, on 07/16/15 at 11:16 AM, revealed she heard Resident #1 crying out over and over on 06/30/15

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at 10:30 AM. She entered the room and saw the resident in the lift sling and the lift was tilted. She stated CNA #2 had the lift sling in her hands and she was pulling the resident into the wheelchair. The resident went down into the wheelchair and CNA #2 was hit in the head by the lift. She stated the lift did not hit the resident and she was told by CNA #1 that the lift did not hit the resident when the lift first tilted. However, she saw pinkness on the resident's forehead and was suspicious, but thought the pinkness was caused by the resident crying out repeatedly.

Continued interview with LPN #2 revealed, on 06/30/15 at 12:30 PM, she noted the resident had a hematoma on the right side of the forehead. She confronted CNA #1 and told the CNA the resident had a lump on the forehead and the bar must have hit the resident when she moved the lift. However, the CNA did not admit to that and stated if it did she was sorry, but she did nothing wrong. The nurse measured the hematoma at 1.5 centimeters by 2 centimeters and notified the Advance Practice Registered Nurse (APRN). The APRN arrived to see the resident between 2:00 PM and 2:30 PM and ordered a Computed Tomography (CAT) Scan be obtained from a local outpatient facility. LPN #2 stated the facility's policy for using the mechanical lift required two (2) persons to do the lift together. She stated Resident #1 was not injured when she was in the room and the injuries resulted from CNA #1's transfer. She stated she was not trained on assessment and identifying injuries by the facility; therefore, could not complete the root cause analysis.

Interview with the Advanced Practice Registered Nurse, on 07/17/15 at 12:00 PM, revealed she

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was at the facility when she was notified, around 12:30 PM, that Resident #1 was hit in the head, during a transfer, bruising the right forehead above the eye.

Interview with the DON, on 07/17/15 at 7:21 PM, revealed staff from an Agency was oriented on lifts prior to working on a unit. She stated nursing staff was trained to review the resident's Kardex to become familiar with the resident's care needs as assessed by the nurse. The DON stated this was a basic part of nursing education. She stated CNA #1 did not follow the facility's policy for using mechanical lifts and the Agency was notified the nurse aide was not to return to the facility.

2. Review of the clinical record for Resident #3, revealed the facility admitted the resident on 05/16/13 with diagnoses of Osteopenia, Pacemaker, Heart Disease, Pressure Ulcer, Hypertension and Dementia.

Review of the Quarterly MDS assessment, dated 06/08/15, revealed the resident had a Brief Interview for Mental Status with a score of nine (9) and was interviewable. The resident required extensive assistance of two (2) for bed mobility and transfers and was unable to ambulate. The resident was incontinent of bowel and bladder.

Review of Resident #3's Comprehensive Care Plan, dated 06/09/15, revealed the resident was at risk for falls due to overall physical condition and use of psychotropic medications. The goal for the resident was to have no injuries related to falls with a goal date of 09/16/15. Interventions included: encourage the resident to ask for assistance; anticipate needs; bilateral one-half

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side rails; bolsters in bed; sensor pad in bed; chair alarm; assist of two (2) when transferring with the mechanical lift; and fall mats.

Review of Resident #3's SBAR Communication Form, dated 07/04/15 at 6:30 PM, revealed Resident #3 was found on the floor, on the floor mat, and the resident's condition remained unchanged after the fall. The assessment (SBAR) of the resident utilized a check off system which documented there were no changes in the resident's condition. There was no documented evidence/description of the resident's physical condition after the fall; what safety interventions were in place at the time of the fall; or, if the bed sensor pad was in place and sounding. There was no documented evidence the resident was interviewed or that a root cause for the fall was determined by the facility. Review of the Fall Root Cause Investigation Report, dated 07/04/15 revealed the potential cause for the fall stated the resident was confused at times.

Review of the resident's Plan of Care revealed an intervention to place the left side of the bed to the wall was added to the Plan of Care on 07/04/15, after the resident fell.

Review of the SBAR Communication Form, dated 07/10/15 at 2:30 PM, revealed Resident #3 was found on the floor, on the floor mat, and the resident's condition remained unchanged after the fall. There was no documented evidence regarding what safety measures were in place when the fall occurred or a statement from the resident regarding what happened to cause the fall. The resident was placed back in bed with a bed alarm, bolsters, left side of bed to the wall, and the bed in low position.

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Review of the Fall Root Cause Investigation Report, dated 07/10/15, revealed the potential cause of the fall was blank.

Interview with Resident #3, on 07/11/15 at 10:14 AM by the State Survey Agency (SSA) during State monitoring of the facility, revealed he/she felt beaten from head to toe and was in pain. The SSA reported the resident's comments to the Corporate Nurse Consultant, who was working onsite at the facility.

Review of the Nursing Progress Notes, dated 07/11/15 at 12:00 PM, revealed Resident #3 was placed in a wheelchair and was out of the room. Attempted interview revealed the resident mumbled something about being beaten up. The resident was transferred back to bed using a lift and two (2) persons. A complete head to toe nursing assessment was completed with no bruises or signs of trauma noted. An x-ray of the right knee was taken with no deformity noted; however, the resident did continue to complain of pain. Further review revealed at 6:30 PM, the Nursing Note stated an x-ray was pending.

Further review of the Nursing Progress Note revealed at 7:00 AM on 07/12/15, the facility was told by the x-ray company that the x-ray was not readable. The x-ray was repeated at 10:00 AM. On 07/12/15 at 7:30 PM, the x-ray results were called to the APRN who ordered the resident be sent to the emergency room for evaluation.

Review of the Orthopedic Surgery Consultation, dated 07/14/15 revealed Resident #3 was extremely apprehensive of anyone approaching him/her or touching the bed secondary to severe

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pain and spasms even without examination, and positive swelling around the supracondylar area of the right knee with some redness. Review of the leg x-ray, dated 07/14/15, revealed Resident #3 had a complete displacement of the supracondylar fracture of the right femur.

Interview with CNA #4, on 07/17/15 at 6:15 PM, revealed Resident #3 did have falls; however, no one had actually seen the resident fall. She stated she did not know how the resident got out of bed and fell and she had no other information.

Interview with RN #1, on 07/17/15 at 6:04 PM, revealed Resident #3 did complain of pain frequently and received narcotics routinely for pain. She stated the resident usually complained of pain when turned. She stated the resident had fallen from the bed and no one knew how the resident got out of the bed. RN #1 stated she filled out the SBAR report to document her assessment and the Root Cause Report to document the hazards for the resident. However, she did not attempt to determine the cause of falls. She stated she assessed the resident after the fall on 07/10/15, and found no injury and no change in the resident's level of pain.

Interview with the DON, on 07/16/15 at 11:53 AM, revealed she was not familiar with root cause analysis and how to complete it. This was why the fall investigation (per the DON was the SBAR) for Residents #1 and #3 did not have the documentation regarding the falls, only the check off of external and internal risk factors. However, review of the facility's policy and procedures revealed the investigation of a fall included the determination of the root cause of the fall using the Root Cause Analysis Investigation Form.

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F 323	Continued From page 32 Further interview with the DON, on 07/17/15 at 7:21 PM, revealed nurses were to assess residents after falls and add an immediate intervention to prevent further falls. She stated all falls were reviewed at the morning meeting attended by herself, the Assistant Director of Nursing, Social Services and Activities and Residents #1 and #3 were reviewed. The DON stated there was no concerns noted.	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, and review of the facility policy and procedures, and the Executive Director's job description it was determined the facility failed to have an effective system in place to ensure the Executive Director efficiently and effectively utilized policies and procedures developed to meet the needs of the residents. This was evidenced by failure to provide adequate supervision to prevent accidents/incidents, determine the root cause and implement interventions to prevent recurrence of falls, assess and monitor residents after an injury, ensure staff followed residents' care plans, and ensure staff followed the facility's policies for equipment used. This was also evidenced by the	F 490		

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facility's continued non-compliance from an abbreviated survey completed on 05/22/15 in which Immediate Jeopardy was also identified at 42 CFR 483.20 Resident Assessment (F282); 42 CFR 483.25 Quality of Care (F309 and F323); and, 42 CFR 483.75 Administration (F490 and F520).

(Refer to F282, F309, F323, F490 and F498)

On 06/30/15 at approximately 10:30 AM, Resident #1 sustained a head injury when a Certified Nurse Aide (CNA) failed to follow the facility's policy and transferred the resident using a mechanical lift without the assistance of another nursing staff member as directed by the resident's plan of care. This action resulted in the lift tilting and the lift bar striking the resident in the face. The resident sustained injuries to the face resulting in severe bruising of the forehead, the periorbital areas (area surrounding the eyes), and the right cheek. Interview and record review revealed the resident did not receive a complete nursing assessment until 12:30 PM when the nurse noticed a 2 centimeter by 1.5 centimeter hematoma on the right side of the resident's forehead.

On 07/04/15 at 6:30 PM, Resident #3 was found on the floor lying on their left side on the floor mat. On 07/10/15 at 2:30 PM, Resident #3 was found on the floor, on the floor mat, and the resident's condition was assessed to be unchanged after the fall; however, the resident had a history of pain and continued to complain of pain. Interview and record review revealed the facility failed to assess or monitor the resident for a change in condition due to the resident's prior history of pain. On 07/11/15, during State

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monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and after Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur.

The facility's failure to have an effective system in place to ensure the Executive Director effectively and efficiently implemented policies, procedures, and resources to ensure residents assessed needs were met, and staff followed the policies and care plans has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing.

The findings include:

Review of the Executive Director's job description, not dated and blank, revealed the primary purpose of the Executive Director was to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care could be provided to the residents at all times. The Executive Director was responsible for hiring a sufficient number of qualified staff to carry out the facility's programs and services; maintain and guide the implementation of facility policies and procedures in compliance with state, federal and other regulatory guidelines; support and guide the facility's quality improvement process; ensure a

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safe, clean and comfortable environment for residents; ensure that residents are treated with respect and compassion; adhere to facility policies and participate in quality improvement; and, maintain resident confidentiality of all resident care information, including protected health information.

Review of the facility's policy regarding Resident Incident/Accident Reports, dated 11/30/14, revealed it was the policy of the company that resident incidents/accidents were recorded, reviewed, and trended through Quality Assurance and Performance Improvement process in order to, as much as possible, provide for resident, staff, and visitor safety. Any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions. The event, along with the assessment, physician and other required notifications would be documented in the clinical record. Resident's family or legal representatives would be notified of the incident. (F282, F309 and F323)

Review of the facility's policy regarding Fall Prevention-Kardex/Care Plan, dated June 2015, revealed the Kardex contained information on preventative measures for falls. The care plan should be updated immediately with new interventions. A new plan must be developed after every fall. There are not isolated incidents. Check in morning meeting and weekly fall meeting. Kardex should be updated and verbal report given to staff for any changes in resident's plan. (F282 and F323)

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Review of the facility's policy for the Low Lift Program, dated 11/30/14, revealed the facility was committed to providing equipment and resources to achieve, as much as practical, a lift free environment for both residents and staff. The Low Lift Program provided an enhanced margin of safety, allowing the staff to comfortably transfer, transport, and maneuver the residents to meet their individual needs. Review of the Invacare Lifts Users Manual, dated 2013, Chapter 7 Lifting the Patient, Item 7.1 Preparing the Lift for Use, revealed a recommendation that two assistants be used for all lifting preparation and transferring. (F282, F323, F498)

The facility policy for Neurological Assessment Flow Sheet, dated March 2013, revealed checks were to be completed: every fifteen (15) minutes for one hour; every hour for four (4) hours; and every four (4) hours for nineteen (19) more hours. (F282 and F309)

Review of the facility's Situation, Background, Appearance Review (SBAR) Communication Form, dated 2014, revealed the situation of the incident, background of the resident's care, resident's evaluation, the appearance of the resident and review and notification to the physician and also to the responsible party was to be documented. (F282, F309 and F323)

Interview with nursing staff and record review revealed Resident #1's care plan required two (2) persons to assist with the mechanical lift. On 06/30/15 at 10:30 AM, the nurse aide was transferring the resident from the bed to the wheelchair using a total body lift without any assistance. The Nurse Aide lost control of the lift

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causing the lift to tilt resulting in the metal lift bar striking the resident in the face. There was no documented evidence of staff competency training prior to mechanical lift usage. There was no documented evidence the resident was monitored for injury until 12:30 PM on 06/30/15. A Computed Tomography (CAT) Scan was obtained on 06/30/15 revealing the injury was a hematoma (a collection of blood under the skin) covering the right side of the head.

Interview with nursing staff and record review for Resident #3 revealed on 07/04/15 the resident was found on the floor beside the bed without any injury. On 07/10/15 the resident was found by staff again on the floor beside the bed. The resident was assessed without injury; however, continued to express pain. The facility was notified of the resident's pain, on 07/11/15 by the State Survey Agency, who interviewed the resident during the facility's monitoring. The resident was hospitalized 07/12/15, two days after the fall, where a fractured femur was diagnosed. Interview revealed the resident's injury should have been assessed throughout the day and night per the facility's policy in order to identify changes that should be brought to the APRN or the physician's attention.

Interview with the Director of Nursing (DON), on 07/16/15 at 11:53 AM, on 07/17/15 at 7:21 PM, and on 07/20/15 at 2:56 PM revealed the CNAs were required to follow residents' care plans when providing care to ensure resident safety. She stated nursing staff was trained to review the resident's Kardex to become familiar with the resident's care needs as assessed by the nurse. Per the DON, nurses were educated on the basics in school and she did not feel they needed

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 490	Continued From page 38 more training in this subject. Interview with the Interim Executive Director, on 07/17/15 at 7:21 PM, revealed he started with the facility on 07/13/15 to assist in the closing of the facility. He stated he was not familiar with the policies and procedures of the facility.	F 490		
F 498 SS=J	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, and the Invacare Manufacturer's User Manual, it was determined the facility failed to have an effective system in place to ensure Agency nurse aides were able to demonstrate competency in the use of the total body lift for one (1) of five (5) sampled residents (Resident #1). Interview and record review revealed on 06/30/15 a Certified Nurse Aide (CNA) used a mechanical lift to transfer Resident #1 from the bed into a wheelchair without assistance. During the transfer, the lift tilted and the metal lift bar hit the resident in the face. The resident developed a hematoma on the right side of the forehead. A Computed Tomography (CAT) Scan was obtained from a local outpatient facility and revealed the resident had a large hematoma to the right forehead. The CNA stated she was not trained	F 498		

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by the facility to physically use the mechanical lift; however, she received verbal quizzing during the orientation about what she had been trained on lifts in the past.

The facility's failure to ensure staff was trained on the use of resident equipment has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing.

The findings include:

Interview with the Director of Nursing (DON), on 07/16/15 at 11:53 AM, revealed the facility did not have a policy regarding the education/training of staff prior to the use of equipment for residents. However, it was the facility's practice to education staff on equipment prior to use if they were new to the facility.

Review of the facility's Low Lift Program, dated 11/30/14, revealed residents were assessed on admission for transfer and mobility status. This information was located on the Nurse Aide Kardex and identified the resident's needs for assistance with transfers and if a mechanical lift was necessary in order to transfer to and from bed. Two (2) staff members were required to assist when a lift was used.

Review of the Invacare Manufacturer's User Manual for mechanical lifts, dated 2013, Chapter 7, Lifting the Patient, item 7.1 page 28, Invacare recommended that two (2) assistants be used for all lifting and transferring.

Review of the clinical record for Resident #1,

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revealed the facility admitted the resident on 05/16/13 with diagnoses of Dementia, Pseudobulbar Affect (a neurological disorder characterized by outbursts of crying, laughing and other emotional expressions).

Review of the quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 06/23/15, revealed the resident was unable to complete the Brief Interview for Mental Status and the facility assessed the resident with a severe impairment of cognition meaning the resident was not interviewable. The resident required extensive assistance of two (2) for bed mobility and transfers. The resident was not able to stand or to ambulate.

Review of the Comprehensive Care Plan, dated 04/08/14, for Resident #1, revealed the resident required extensive to dependent assistance with activities of daily living. An intervention was added on 04/30/15 for the resident to be transferred to and from the bed with a lift and two (2) assistants.

Review of the Nurse Aide Kardex, undated, revealed Resident #1 required the use of a total body mechanical lift with two (2) assistants.

Review of the Situation, Background, Appearance, and Review (SBAR), dated 06/30/15 at 1:00 PM, revealed Resident #1 was injured when CNA #1 transferred the resident with a mechanical lift without assistance from the bed. During the transfer, the bar from the lift likely hit the resident in the head.

Interview with CNA #1, on on 06/30/15 at 10:30 AM and 07/16/15 at 4:52 PM, revealed she

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worked for an Agency and had been working at the facility for three (3) months. She stated she had provided care for Resident #1 in the past. She stated she was aware of the care instructions for Resident #1 regarding using the mechanical lift with an extra large sling to transfer the resident from the bed or chair. She stated she was aware that Resident #1's care plan called for nursing staff to use a mechanical lift for transfers but she did not remember seeing the requirement for two (2) staff, although she stated she had reviewed the resident's Kardex. She further stated she was aware of the policy for two (2) persons to use a mechanical lift and follow the care plan. Per interview, the facility asked her a few questions about the mechanical lift and had her sign a form saying she was oriented on the lift but there was no return demonstration during her orientation to the facility.

However, review of the Employee Education Checklist for CNA #1, revealed the CNA was provided training on the mechanical lift, and included in the training was a demonstration using the lift.

Interview with the Director of Nursing (DON), on 07/16/15 at 11:53 AM, revealed CNA #1 signed off the Employee Education Checklist for use of mechanical lifts on 05/13/15. She stated all nurse aides from Agencies received orientation prior to going to work on the units. She stated she did not think she oriented this nurse aide on lifts; however, her signature was present on the checklist. She could not specify who might have oriented this CNA. She stated the nurse aide was not newly certified and had worked at the facility for several months. Per interview, the DON could not confirm if the CNA completed a return

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F 498	Continued From page 42 demonstration on the use of the lift. However, interview with CNA #1 revealed she was only asked questions on how to use a lift.	F 498		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedures, and the Allegation of Compliance for the 05/22/15	F 520		

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survey it was determined the facility failed to have an effective Quality Assurance/Performance Improvement Committee (QA) to investigate and develop plans of action in response to identified deficiencies. This was evidenced by the facility's continued non-compliance from an abbreviated survey completed on 05/22/15 in which Immediate Jeopardy was also identified at 42 CFR 483.20 Resident Assessment (F282); 42 CFR 483.25 Quality of Care (F309 and F323); and, 42 CFR 483.75 Administration (F490 and F520).

(Refer to F282, F309, F323 and F490)

On 06/30/15 at approximately 10:30 AM, Resident #1 sustained a head injury when a Certified Nurse Aide (CNA) failed to follow the facility's policy and transferred the resident using a mechanical lift without the assistance of another nursing staff member as directed by the resident's plan of care. This action resulted in the lift tilting and the lift bar striking the resident in the face. The resident sustained injuries to the face resulting in severe bruising of the forehead, the periorbital areas (area surrounding the eyes), and the right cheek. Interview and record review revealed the resident did not receive a complete nursing assessment until 12:30 PM when the nurse noticed a 2 centimeter by 1.5 centimeter hematoma on the right side of the resident's forehead.

On 07/04/15 at 6:30 PM, Resident #3 was found on the floor lying on their left side on the floor mat. On 07/10/15 at 2:30 PM, Resident #3 was found on the floor, on the floor mat, and the resident's condition was assessed to be unchanged after the fall. There was no

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documented evidence the facility identified the root cause of these falls to implement interventions to prevent recurrence. On 07/11/15, during State monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and after Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur.

The facility's failure to have an effective Quality Assurance Committee in place to identify quality deficiencies and to develop effective action plans to resolve those deficiencies has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing.

The findings include:

Review of the facility's policy regarding Quality Assurance/Performance Improvement Committee (QA), dated 11/30/14, revealed the Quality Assurance Committee would meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee would direct all activities including approving proposed monitoring, evaluating, and review of services. The committee would assure activities had written indicators and standard/thresholds for evaluation, that appropriate actions are implemented, and that such correction had been evaluated by subsequent monitoring.

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Review of the facility's Allegation of Compliance for the 05/22/15 survey revealed the Executive Director and corporate staff would perform QI monitoring of regulation F520 to ensure the committee maintained, developed and implemented appropriate plans of action to correct identified quality deficiencies. QI monitoring would be completed three times a week for four weeks, twice a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance was achieved by attending the daily department head meeting and would report findings to two (2) quarterly QAPI committee meetings.

Interview with the Director of Nursing, on 07/17/15 at 7:21 PM, revealed the QA Committee met monthly to review care areas of concern and to develop plans of action to resolve these areas and to monitor for compliance. She stated the facility used various methods to identify deficient practices. She stated there were mock survey rounds made daily and weekly safety tours to ensure residents had all safety interventions in place. She stated the facility obtained information when residents and families submitted grievances. She stated all Accident/Incident reports were reviewed daily in a meeting. In addition, all physician orders were reviewed daily. She stated the facility worked on staffing; however, she was not able to provide specifics. Per interview, no issues had been identified.

Interview with the Executive Director, on 07/17/15 at 7:21 PM, revealed he was not familiar with the facility or it's policies at this time. He further stated the Quality Assurance Committee had not convened since his employment date of 07/13/15.